PRINTED: 01/17/2012 FORM APPROVED

(X6) DATE

## Division of Health Care Facilities

				(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING		C <b>09/30/2010</b>		
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
HARRIMAN CARE & REHAB CENTER		240 HANNAH ROAD HARRIMAN, TN 37748					
			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETI  DATE		
N 002 1200-8-6 No Deficiencies			N 002				
This Rule is not met as evidenced by: During investigation of complaint #24861, #25727, # 26416, and #26725, conducted at Harriman Care and Reha Center, on September 7 - 9, 2010, no deficient practices were cited under Chapter 1200-08-06, Standards for Nursing Homes.							
alth Care Facilities							
	OVIDER OR SUPPLIER  N CARE & REHAB CEN  SUMMARY ST (EACH DEFICIENC REGULATORY OR  1200-8-6 No Deficier  This Rule is not met During investigation of #25727, # 26416, an Harriman Care and F 7 - 9, 2010, no deficient under Chapter 1200-Homes.	TN7303  OVIDER OR SUPPLIER  N CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT  1200-8-6 No Deficiencies  This Rule is not met as evidenced by: During investigation of complaint #24861, #25727, # 26416, and #26725, conducted a Harriman Care and Reha Center, on Septen 7 - 9, 2010, no deficient practices were cited under Chapter 1200-08-06, Standards for N Homes.	OVIDER OR SUPPLIER  N CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1200-8-6 No Deficiencies  This Rule is not met as evidenced by: During investigation of complaint #24861, #25727, # 26416, and #26725, conducted at Harriman Care and Reha Center, on September 7 - 9, 2010, no deficient practices were cited under Chapter 1200-08-06, Standards for Nursing Homes.	OVIDER OR SUPPLIER  IN CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1200-8-6 No Deficiencies  This Rule is not met as evidenced by: During investigation of complaint #24861, #25727, # 26416, and #26725, conducted at Harriman Care and Reha Center, on September 7 - 9, 2010, no deficient practices were cited under Chapter 1200-08-06, Standards for Nursing Homes.	OVIDER OR SUPPLIER  N CARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  This Rule is not met as evidenced by: During investigation of complaint #24861, #25727, #26416, and #26725, conducted at Harriman Care and Reha Center, on September 7 - 9, 2010, no deficient practices were cited under Chapter 1200-08-06, Standards for Nursing Homes.	TN7303  STREET ADDRESS, CITY, STATE, ZIP CODE  A BUILDING B, WING B, WING BLOWN BRITTER  SUMMARY STATEMENT OF DEFICIENCIES  N 002  PROVIDERS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG  N 002  N 002  This Rule is not met as evidenced by: During investigation of complaint #24861, #25727, #28416, and #26725, conducted at Harriman Care and Reha Center, on September 7 - 9, 2010, no deficient practices were cited under Chapter 1200-08-06, Standards for Nursing Homes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 DR5H11 If continuation sheet 1 of 1

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